Three-Tier Co-payment Structure

All GIC health plans have a three-tier co-payment structure in which members generally pay less for generic drugs and more for brand name drugs. The three-tier system maintains a broad choice of covered drugs for patients and their doctors, while providing an incentive to use medications that are safe, effective and less costly.

For most plans, the formulary changes every January. The GIC recommends that you bring your current plan formulary with you to your doctor visits. Frequently there is more than one prescription drug that your doctor could prescribe for a particular illness or condition. ***Discuss with your doctor whether drugs with lower co-payments are appropriate for you.***

The following descriptions will help you understand your prescription drug co-payment levels. *See the Benefits-at-a-Glance charts on pages 14-21 for the corresponding co-payment information.* (Some plans categorize their prescription drug tiers differently from those listed below. Call the plans for more information.)

Generic: Generic drugs contain the same active ingredients as brand name drugs and are sold under their chemical name. These drugs are subject to the same rigid FDA standards for quality, strength, and purity as the brand name drug. Generic drugs cost less than brand name drugs because they do not require the same level of sales, advertising, and development expenses associated with brand name drugs.

Preferred Brand Name/Formulary: The manufacturer sells these drugs under a trademarked name. Preferred brand name drugs usually do not have less costly generic equivalents.

Non-Preferred Brand Name/Non-Formulary: These drugs are also trademarked. They have a generic equivalent or a preferred brand alternative that can be substituted.

Mail Order Convenience and Savings

If you are taking a medication for a long period of time, you may want to ask your doctor for a 90-day prescription, so you can take advantage of mail order savings. All GIC plans offer this convenient means of obtaining a 90-day supply of drugs prescribed to members for long-term use. For example, if you are an indemnity plan member and are taking a maintenance dose of a preferred brand name drug, you will spend $60 on co-payments over three months; if you use mail order, you will spend only $40. *See the Benefits-at-a-Glance charts on pages 14-21 for similar savings in other GIC plans.*

Pharmacy programs will send new enrollees mail order information.

Prescription Drug Benefits for Commonwealth Indemnity Plans

Members of the Commonwealth Indemnity Plan, Commonwealth Indemnity Medicare Extension (OME) Plan, Commonwealth Indemnity Plan PLUS, and Commonwealth Indemnity Community Choice Plan have two programs that help encourage the use of less expensive prescription drugs:

Step Therapy: The Step Therapy program encourages the most appropriate drug therapy for certain conditions. The program provides coverage for some expensive drug treatments only after safe, effective and less expensive drug treatments are tried first.

Generics Preferred: This program provides an incentive for members to obtain the generic version of a brand name drug. If you obtain a prescription for a non-preferred brand name drug for which there is a generic version, you will pay the generic drug co-pay as well as the difference between the cost of the generic drug and the cost of the non-preferred brand name drug.

Commonwealth Indemnity Plans' Prescription Drug Benefit Questions?
Contact Express Scripts
1.877.828.9744
www.express-scripts.com

For example, for a 30-day supply obtained at a retail pharmacy, if the cost of the generic drug version of a non-preferred brand name drug is $30, you will pay only the generic co-pay of $7. However, if you select the brand version, with a cost of $50, you will pay the generic drug co-pay as well as the difference in the drug cost, or $27. This program also applies to mail-order services.

BENEFITS-AT-A-GLANCE *With* Medicare

This chart is an overview of the plan benefits. It is not a complete description. Benefits are subject to certain definitions, conditions, limitations and exclusions as spelled out in the respective plan documents.

BENEFITS	COMMONWEALTH INDEMNITY MEDICARE EXTENSION PLAN (OME) with CIC[1] (Comprehensive) UNICARE	FALLON SENIOR PLAN PREFERRED[2]
TELEPHONE NUMBERS	**1.800.442.9300**	**1.800.868.5200**
WEBSITES	**www.unicare-cip.com**	**www.fchp.org**
Preventive Care *office visits according to schedule*[3]	100%, after $5 per visit	100%, after $10 per visit
Physician Office Visit *(except mental health)*	100%, after $35 calendar year deductible	100%, after $10 per visit
Inpatient Hospital *room, board, and special services*	100%, after $50 deductible per quarter	100%
Hospice Care	100%, after $35 calendar year deductible	100%
Diagnostic Laboratory Tests and X-rays	100%	100%
Surgery *Inpatient & Outpatient*	100% within MA; call the plan for out-of-state details	100%
Emergency Room Care *(includes out-of-area)*	100%, after $25 co-pay per visit *(waived if admitted)* *(calendar year deductible may apply)*	100%, after $50 co-pay per visit *(waived if admitted)*
Hearing Aids	First $500 covered at 100%; 80% coverage for the next $1,500 per person, per two-year period	
Prescription Drugs[4] *Network Pharmacy* Up to 30-day supply	$7 generic $20 preferred brand name $40 non-preferred brand name[5]	$8 tier I $15 tier II $35 tier III
	No coverage is available for out-of-network drugs.	
Mail Order Maintenance Drugs Up to 90-day supply	$14 generic $40 preferred brand name $70 non-preferred brand name[5]	$16 tier I $30 tier II $105 tier III
Intermediate & Inpatient Mental Health & Substance Abuse Care	Medically necessary intermediate and inpatient care for mental health and substance abuse treatment are covered. Authorizations vary by plan.	
Outpatient Mental Health Care	See page 18 for details.	100%, after $10 per visit
Outpatient Substance Abuse Care	See page 18 for details.	100%, after $10 per visit

[1] *Without CIC (non-comprehensive), deductibles are higher and coverage is only 80% for some services.*

[2] *Benefits and rates of Fallon Senior Plan Preferred and Harvard Pilgrim First Seniority are subject to change January 1, 2005.*

For more information about a specific plan's benefits or providers, call the plan or visit its website.

HARVARD PILGRIM HEALTH CARE FIRST SENIORITY[2]	HEALTH NEW ENGLAND MEDRATE	TUFTS HEALTH PLAN MEDICARE COMPLEMENT	TUFTS HEALTH PLAN SECURE HORIZONS
1.800.779.7723	**1.800.842.4464**	**1.800.870.9488**	**1.800.867.2000**
www.harvardpilgrim.org	**www.healthnewengland.com**	**www.tuftshealthplan.com**	**www.tuftshealthplan.com**
100%, after $10 per visit	100%, after $10 per visit	100%, after $10 per visit	100%, after $10 per visit
100%, after $10 per visit	100%, after $10 per visit	100%, after $10 per visit	100%, after $10 per visit
100%			
100%			
100%			
100%			
100%, after $50 co-pay per visit *(waived if admitted)*			
First $500 covered at 100%; 80% coverage for the next $1,500 per person, per two-year period			
$10 generic $20 brand name select $35 brand name non-select	$10 generic $20 brand name formulary $40 brand name non-formulary	$8 generic $20 brand name $35 non-preferred brand name	$15 generic $25 brand name $50 non-preferred brand name
No coverage is available for out-of-network drugs.			
$20 generic $40 brand name select $105 brand name non-select	$20 generic $40 brand name formulary $120 brand name non-formulary	$16 generic $40 brand name $70 non-preferred brand name	$30 generic $50 brand name $100 non-preferred brand name
Medically necessary intermediate and inpatient care for mental health and substance abuse treatment are covered. Authorizations vary by plan.			
100%, after $5 per visit	100%, after $10 per visit	100%, after $10 per visit	100%, after $10 per visit
Visit(s) 1-8: 100%, after $5 per visit; Visits 9-20: 100%, after $25 per visit Visits 21 and up: 50%	100%, after $10 per visit	100%, after $10 per visit	100%, after $10 per visit

[3] *Contact the plan for the schedule.*
[4] *Contact the individual plan to find out how a specific drug is categorized.*
[5] *Additional charges may apply. See page 13 for details.*

BENEFITS-AT-A-GLANCE *Without* Medicare: New Health Plans

This chart is a comparative overview of plan benefits. It is not a complete description. Benefits are subject to certain definitions, conditions, limitations and exclusions as spelled out in the respective plan documents.

BENEFITS	COMMONWEALTH INDEMNITY COMMUNITY CHOICE PLAN		HARVARD
	Community Choice Network	Out-of-Network[1]	Harvard Pilgrim POS
PROVIDER	**UNICARE**		**Harvard Pilgri**
TELEPHONE NUMBERS	**1.800.442.9300**		**1.800.5**
WEBSITES	**www.unicare-cip.com**		**www.harvar**
Hospital Care Inpatient hospital room, board, surgery and special services	100%	100%	100%
	after hospital deductible/co-pay		
Hospice Care	100%	100%	100%
Emergency Room Care *(includes out-of-area)*	100% after $50 co-pay *(waived if admitted)*	100% after $100 co-pay *(waived if admitted)*	100% after *(waived if*
Outpatient Surgery	100%	100%	100%
	after outpatient surgery deductible/co-pay		
Diagnostic Laboratory Tests	100%[3]	100% after $50 co-pay *(Hospital)* 80% *(non-Hospital)*	100%
X-rays	100%	100% after $50 co-pay	100%
Physician Office Visit and Preventive Care ***(except mental health)*** Preventive care and well baby care office visits according to schedule[4] and immunizations.	100%, after $10 per visit		100%, after $15 per visit. No co-pay after 15th calendar year visit per person.
Hearing Aids	First $500 covered at 100%; 80% coverage for the nex		
Inpatient Hospital Deductible/ Co-pay	$200 per admission; maximum one deductible per calendar quarter per person	$750 per admission	$400 per admission; maximum 1 co-pay per calendar quarter per person
Outpatient Surgery Deductible/ Co-pay	$75 per occurrence; maximum one deductible per calendar quarter per person	$250 per occurrence	$75 per occurrence; maximum 4 co-pays annually per person
Calendar Year Deductible			
Individual	$0	$0	$0
Family	$0	$0	$0
Prescription Drugs[5] *Network Pharmacy* – Up to a 30-day supply	$7 generic, $20 preferred brand name, $40 non-preferred brand name[6] drugs using an Express Scripts, Inc. network pharmacy and your prescription drug card.		$10 generic, $20 brand na non-select drugs using a H network pharmacy and y
			No coverage is available for ou
Mail Order – Maintenance drugs up to a 90-day supply	$14 generic, $40 preferred brand name, $70 non-preferred brand name drugs[6]		$20 generic, $40 b $80 brand name
Inpatient and Intermediate Mental Health and Substance Abuse Care	*See page 18*		100%, after $200 per admission; maximum 1 co-pay per calendar quarter
Outpatient Mental Health, EAP and Substance Abuse Care	*See page 18*		Visits 1-4: 100%; Visits 5 & over: 100% after $15 per individual visit or $10 per group visit

[1] *Benefits subject to reasonable and customary charges. Members may be responsible for a portion of the total charge.*
[2] *Hospitals are grouped by pediatrics, obstetrics and adult medical/surgical services. Hospital Level I: high quality/high efficiency, Level II: standard quality/standard efficiency.*

RMTs and EGRs are not eligible for these Plans.

For more information about plan designs, call the plan or visit its website.

PILGRIM POS		NAVIGATOR PPO BY TUFTS HEALTH PLAN	
Out-of-Network[1]		Tufts Plan Network	Out-of-Network[1]
im Health Care		**Tufts Health Plan**	
42.1499		**1.800.870.9488**	
rdpilgrim.org		**www.tuftshealthplan.com/gic**	
80%	After calendar year deductible, $3,000 out-of-pocket max. per person	100% after hospital co-pay based on specialty and level[2]	80% After calendar year deductible, $3,000 out-of-pocket max. per person
80%		100%	80%
$50 co-pay *f admitted)*		100%, after $50 co-pay *(waived if admitted)*	
80%	After calendar year deductible, $3,000 out-of-pocket maximum per person	100% after outpatient surgery deductible/co-pay	80% After calendar year deductible, $3,000 out-of-pocket maximum per person
80%		100%	80%
80%		100%	80%
80%		100%, after $15 per visit. No co-pay after 15th calendar year visit per person.	80%
t $1,500 per person, per two-year period.			
Not applicable		$200 Level I, $400 Level II, per admission[2]; maximum 1 co-pay per calendar quarter per person	Not applicable
Not applicable		$75 per occurrence; maximum 4 co-pays annually per person	Not applicable
Medical / Mental Health & Substance Abuse			
$150 / $150		$0 / $0	$150 / $300
$300 / $300			
me select, $40 brand name Harvard Pilgrim Health Care our Harvard Plan ID card.		$10 generic, $20 brand name, $35 non-preferred brand name drugs using a Tufts Health Plan network pharmacy and your Tufts ID card.	
t-of-network prescription drugs.			
brand-name select, non-select drugs		$20 generic, $40 brand name, $70 non-preferred brand name drugs	
80%, after $150 per admission		*See page 18*	
Visits 1-15: 80% Visits 16 and over: 50%		*See page 18*	

[3] *Includes preferred vendors and/or physicians' offices.*
[4] *Contact the health plan for the schedule.*
[5] *Contact the plan to find out how a specific drug is categorized.*
[6] *Additional charges may apply. See page 13 for details.*

NEW *Non-Medicare* Health Plan Options

Community Choice Plan (UNICARE)

The Commonwealth Indemnity Community Choice Plan gives members access to any Massachusetts physician. There are no Primary Care Physician or referral notification requirements. Participating members needing hospital care receive the highest benefit when they have routine procedures, such as appendectomies and hernia repair, at one of the 40 participating hospitals. If you are having certain designated complex procedures, such as a coronary artery bypass, additional hospitals with extensive experience in these complex procedures are also covered at the highest benefit level.

The Harvard Pilgrim POS Plan

The Harvard Pilgrim Point of Service (POS) Plan offers coverage by network doctors, hospitals, and other health care providers within the plan's geographic area. Members must choose a Primary Care Physician to coordinate care and obtain referrals. Members may also choose to go outside of Harvard Pilgrim Health Care's provider network, subject to higher out-of-pocket costs. For the next fiscal year (FY06), HPHC will establish tiers of provider groups based on cost and quality. Details will be in next year's *Benefit Decision Guide*.

Navigator PPO by Tufts Health Plan

The Tufts Navigator Plan, a PPO, offers coverage by physicians, specialists and hospitals without referral from a Primary Care Physician. Members may also choose to go outside of Tufts Health Plan's provider network, subject to higher out-of-pocket costs. Your level of hospital benefits is determined by your hospital choice each time that you seek services. For example, if you need to be admitted to the hospital, Tufts Health Plan will provide information on the quality and value of hospitals within the Tufts Health Plan provider network in your area, and your co-payments under the Tufts Navigator Plan will be lower if you choose a high quality, more efficient hospital.

For the Commonwealth Indemnity Plan, Commonwealth Indemnity Medicare Extension (OME) Plan, Commonwealth Indemnity Plan PLUS, Commonwealth Indemnity Community Choice Plan and Navigator by Tufts Health Plan

Mental health and substance abuse benefits for the Commonwealth Indemnity Plan, Commonwealth Indemnity Medicare Extension (OME) Plan, Commonwealth Indemnity Plan PLUS, Commonwealth Indemnity Community Choice Plan and Navigator by Tufts Health Plan are provided by United Behavioral Health (UBH). UBH offers a full range of confidential, professional mental health and substance abuse services. UBH clinical staff can help you find a conveniently located network provider and will work with you to make sure you receive the help you need, when you need it. The chart below is an overview of mental health and substance abuse benefits.

BENEFITS	COVERAGE	
	In-Network	Out-of-Network
CONTACT INFORMATION	**1.888.610.9039 www.liveandworkwell.com** ***(access code: 10910)***	
Annual Deductible *(Separate from the medical deductible and out-of-pocket maximum)*	None	$100 per person *(Medicare Extension OME)* $150 per person *(Indemnity Plan, PLUS, Community Choice, and Tufts Navigator)* $75 per person *(RMT, EGR)*
Inpatient Care ***Per Admission Deductible*** ***Mental Health*** General hospital Psychiatric hospital ***Substance Abuse***[1] General hospital or substance abuse facility	$150 per calendar quarter *(Indemnity)* $200 per calendar quarter *(PLUS, Community Choice and Tufts Navigator)* $50 per calendar quarter *(Medicare Extension OME)* 100%	$150 per admission 80%[2]
Intermediate Care[3] *(Including, but not limited to, 24-hour intermediate care facilities, e.g., residential, group homes, halfway houses, therapeutic foster care, day/partial hospitals, structured outpatient treatment programs.)*	100%	80%
Outpatient Care[3] *(Including, but not limited to, individuals, family, group therapy, and medication management.)* ***Enrollee Assistance Program (EAP):*** *(Including, but not limited to, depression, marital issues, family problems, alcohol and drug abuse, and grief. Also includes referral services – legal, financial, family mediation, and elder care.)*	First 4 visits: 100% Visits 5 and over: $15 per visit *(Indemnity, PLUS, Community Choice and Tufts Navigator)* $10 per visit *(Medicare Extension OME)*	First 15 visits: 80% per visit Visits 16 and over: 50% per visit[4] No coverage for EAP
In-Home Mental Health Care[3]	100%	First 15 visits: 80% per visit Visits 16 and over: 50% per visit[4]
Provider Eligibility	MD Psychiatrist, PhD, EdD, PsyD, MSW, LICSW, MSN, MA, RNMSCS	MD Psychiatrist, PhD, EdD, PsyD, MSW, LICSW, MSN, MA, RNMSCS

[1] *Substance Abuse Incentive – Members reimbursed for inpatient and outpatient co-pays if they complete inpatient and post-discharge care.*
[2] *Out-of-network inpatient care that is not pre-certified is subject to a financial penalty.*
[3] *Treatment that is not pre-certified receives out-of-network-level reimbursement.*
[4] *All outpatient out-of network visits beyond session 15 require pre-authorization.*

BENEFITS-AT-A-GLANCE *Without* Medicare: *Commonwealth Indemnity & PLUS*

This chart is a comparative overview of plan benefits. It is not a complete description. Benefits are subject to certain definitions, conditions, limitations and exclusions as spelled out in the respective plan documents.
For more information about plan designs, call the plan or visit its website.

BENEFITS	COMMONWEALTH INDEMNITY PLAN[1] WITH CIC[2] (Comprehensive)	COMMONWEALTH INDEMNITY PLAN PLUS	
		PLUS Network	Out-of-Network[1]
PROVIDER	**UNICARE**	**UNICARE**	
TELEPHONE NUMBERS	**1.800.442.9300**	**1.800.442.9300**	
WEBSITES	**www.unicare-cip.com**	**www.unicare-cip.com**	
Hospital Care Inpatient hospital room, board, surgery and special services	100%	100%	80%
	after hospital deductible		
Hospice Care	100% after calendar year deductible	100%	100% after calendar year deductible
Emergency Room Care *(includes out-of-area)*	100% after $50 co-pay *(waived if admitted)*		
Outpatient Surgery	100%	100%	80%
		after outpatient surgery deductible	
Diagnostic Laboratory Tests	100% with preferred provider 80% of allowed charges without preferred provider	100%	80%
X-rays	100%	100%	80%
Physician Office Visit *(except mental health)*	100%, after $10 per visit and calendar year deductible	100%, after $10 per visit	80% after $10 per visit and calendar year deductible
	No co-pay after 15th calendar year visit per person		
Preventive Care Preventive care and well baby care office visits according to schedule[3] and immunizations.	100%, after $10 per visit	100% after $10 per visit	80% after $10 per visit
Hearing Aids	First $500 covered at 100%; 80% coverage for the next $1,500 per person, per two-year period.		
Inpatient Hospital Deductible per quarter	$150	$200	$300
Outpatient Surgery Deductible	$0	$75 per calendar quarter	$75 per calendar quarter
Calendar Year Deductible *Individual* *Family*	$75 Two members at $75 each	$0 $0	$100 Two members at $100 each
Prescription Drugs[4] *Network Pharmacy* – Up to a 30-day supply	$7 generic, $20 preferred brand name, $40 non-preferred brand name drugs[5] using an Express Scripts, Inc. network pharmacy and your prescription drug card.		
	No coverage is available for out-of-network prescription drugs.		
Mail Order – Maintenance drugs up to a 90-day supply	$14 generic, $40 preferred brand name, $70 non-preferred brand name[5].		
Mental Health & Substance Abuse Care	*See page 18*		

[1] *Benefit payments to out-of-state providers are determined by allowed amounts. Members may be responsible for a portion of the total charge.*
[2] *Without CIC (non-comprehensive) deductibles are higher and coverage is only 80% for some services.*
[3] *Contact the health plan for the schedule.*
[4] *Contact Express Scripts to see how a specific drug is categorized.*
[5] *Additional charges may apply. See page 13 for details.*

BENEFITS-AT-A-GLANCE *Without* Medicare: HMO

This chart is a comparative overview of HMO benefits. It is not a complete description. Benefits are subject to certain definitions, conditions, limitations and exclusions as spelled out in the respective plan documents.

BENEFITS	FALLON COMMUNITY HEALTH PLAN DIRECT CARE	FALLON COMMUNITY HEALTH PLAN SELECT CARE
TELEPHONE NUMBERS	**1.800.868.5200**	**1.800.868.5200**
WEBSITES	**www.fchp.org**	**www.fchp.org**
Inpatient Hospital Care Inpatient hospital room, board, surgery and special services	100%, after $250 co-pay per admission. Maximum of four co-pays annually. Administration of co-pay maximums differs among plans. Call plans for details.	
Outpatient Surgery	100%, after $75 co-pay per occurrence. Maximum of four co-pays annually. Administration of co-pay maximums differs among plans. Call plans for details.	
Diagnostic Laboratory Tests and X-rays	100%	
Hospice Care	100%	
Emergency Room Care *(Includes out-of-network)*	100% after $75 co-pay per visit for all plans *(waived if admitted)*.	
Physician Care		
Primary Care Physician Office Visits	100%, after $10 per visit	100%, after $15 per visit
Specialist Physician Office Visits	100%, after $15 per visit	100%, after $20 per visit
Preventive Care Office Visits *according to schedule[1] and immunizations.*	Adult: 100%, after $10 per visit Child: 100%	Adult: 100%, after $15 per visit Child: 100%, after $5 per visit
	100%, after $150 per individual; $250 per family	100%, after $225 per individual; $375 per family
	Administration of visit co-pay maximums differs among plans. Call plans for details.	
Hearing Aids	First $500 covered at 100%; 80% coverage for the next $1,500 per person, per two-year period.	
Prescription Drugs[2] ***Network Pharmacy*** Up to a 30-day supply	$5 tier I $20 tier II $60 tier III	$5 tier I $20 tier II $60 tier III
Mail Order Maintenance drugs up to a 90-day supply	$10 tier I $40 tier II $180 tier III	$10 tier I $40 tier II $180 tier III
Intermediate and Inpatient Mental Health and Substance Abuse Care	Medically necessary intermediate and inpatient care for mental health and substance abuse treatment are covered in full. Authorizations vary by plan.	
Outpatient Mental Health and Substance Abuse Care	100%, after $10 per visit	100%, after $15 per visit
	100%, after 15th visit annually per individual, 25th visit annually per family. Administration of visit co-pay maximums differs among plans. Call plans for details.	

[1] *Contact the health plan for the schedule.*
[2] *Contact the individual plan to find out how a specific drug is categorized.*

HEALTH NEW ENGLAND	NEIGHBORHOOD HEALTH PLAN
1.800.842.4464	1.800.433.5556
www.healthnewengland.com	www.nhp.org
100%, after $200 co-pay per admission. Maximum of four co-pays annually. Administration of co-pay maximums differs among plans. Call plans for details.	
100%, after $75 co-pay per occurrence. Maximum of four co-pays annually. Administration of co-pay maximums differs among plans. Call plans for details.	
100%	100%
100%	100%
100% after $50 co-pay per visit for all plans *(waived if admitted).*	
100%, after $15 per visit 100% after 15th visit annually per individual, 25th visit annually per family.	
Administration of visit co-pay maximums differs among plans. Call plans for details	
First $500 covered at 100%; 80% coverage for the next $1,500 per person, per two-year period.	
$10 generic $20 brand name formulary $40 brand name non-formulary	$10 generic $20 preferred brand name $40 non-preferred brand name
$20 generic $40 brand name formulary $120 brand name non-formulary	$20 generic $40 preferred brand name $120 non-preferred brand name
Medically necessary intermediate and inpatient care for mental health and substance abuse treatment are covered in full. Authorizations vary by plan.	
100%, after $15 per visit	
100%, after 15th visit annually per individual, 25th visit annually per family. Administration of visit co-pay maximums differs among plans. Call plans for details.	

For more information about a specific plan's benefits or providers, call the plan or visit its website.